Workforce Issues in Patient Centered Medical Home/Care Coordination Models
Developing a Strategic Approach
January 15, 2014

As healthcare organizations move to implement patient centered medical home and care coordination models, a key component is having the right workforce in place. New models of care require team models, care coordination expertise, and patient centered support. The Montana Healthcare Workforce Advisory Council and the Montana Heath Care Forum have sponsored discussions on this important topic, with input from CSI staff and members of the PCMH Stakeholder Council. Important considerations include:

I. Care Coordination Workforce Issues

a. Who makes up the care team?
b. Training for new roles – community health workers, patient navigators, care coordinators
c. Training for the existing workforce – physicians, nurses, pharmacists, social workers, others
d. Interprofessional and team training
e. Developing common language, credentials and expectations for the care coordination workforce

II. National Developments in Coordinating Care Workforce

a. NASHP, IMPACT
b. What are other states experiencing?

III. State of Care Coordination in Montana

a. Community Health Centers PCMH
b. Hospital and Health System PCMH and Care Coordination
c. Frontier Community Health Integration Project Care Coordination Demonstration
d. Frontier Better Medicine Project (Superior, CAHs)
e. Other

IV. Payment Models that Support a Care Coordination Workforce

Recent and Upcoming Efforts

I. Healthcare Forum Presentations on PCMH Workforce Issues (Nov. 2013)
II. MT Healthcare Workforce Advisory Committee Care Coordination Planning Session (Dec. 2013)
III. Planning Session on Training Community Health Workers (Jan. 28, 2013)
IV. Inventory of PCMH/Care Coordination Workforce Strategies
    a. CHW in progress